



## PROVIDER REPORT FORM

**INSTRUCTIONS:** Please complete this form in as much detail as possible to report a concern with a health plan. As part of our ongoing oversight of all California health plans, these provider reports will be monitored by the Department of Managed Health Care to identify systemic problems and take appropriate action.

***If you are reporting a concern that involves a disruption of health care or services for a patient, please contact our HMO Help Center immediately at 1-888-HMO-2219.***

### **PROVIDER INFORMATION**

Legal Name of Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Name/Telephone Number: \_\_\_\_\_

Street Address of Provider: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### **HEALTH PLAN INFORMATION**

Please identify the health plan(s) that is/are involved.

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Do you have an existing contract with the health plan(s)? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please identify the name and address of any medical group(s) involved.

Name	Address	Contact/Telephone

Do you have an existing contract with the medical group(s)? \_\_\_\_\_ Yes \_\_\_\_\_ No



**REPORTED PROBLEM**

Does this report pertain to problem(s) with claims payments for services provided? If yes, please indicate the specific concern:

- |  |  |
|--|--|
| <input type="checkbox"/> No response to claims submitted | <input type="checkbox"/> Bankruptcy/provider group closure                   |
| <input type="checkbox"/> Inadequate payment              | <input type="checkbox"/> Coordination of benefits                            |
| <input type="checkbox"/> Payment denied                  | <input type="checkbox"/> Unreasonable request for additional medical records |
| <input type="checkbox"/> Failure to pay interest         | <input type="checkbox"/> Other (please identify)                             |
| <input type="checkbox"/> Delay in processing claims      | <input type="checkbox"/> Request for Reimbursement of Overpayment            |

**Claim Information:**

Name of enrollee \_\_\_\_\_

Enrollee ID number \_\_\_\_\_

Date of service \_\_\_\_\_

Claim number \_\_\_\_\_

Claim amount \_\_\_\_\_

Was service preauthorized \_\_\_\_\_ Yes \_\_\_\_\_ No

Health Plan \_\_\_\_\_

Medical Group \_\_\_\_\_

- ☐ Check here if complaint involves more than one enrollee and you have submitted claims information for each enrollee on Attachment A

Approximate timeframe(s) of services rendered:

\_\_\_\_\_

If your concern is not related to claims payment, please describe the problem that you are reporting:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you contacted the health plan(s) about your concerns? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you utilized the health plan's provider dispute resolution process? \_\_\_\_\_ Yes \_\_\_\_\_ No

Plan Contact for Dispute Resolution/Telephone \_\_\_\_\_

Please describe the response you received from the health plan(s):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please mail or fax your completed Provider Report Form to:

**Department of Managed Health Care**  
**Attention: HMO Help Center/Provider Desk**  
**980 9<sup>th</sup> Street, Suite 500**  
**Sacramento, CA 95814**  
**Fax: 916-229-0465**

*Submission of this form to the Department is not a substitute for any legal recourse you may have against the entity from whom you seek payment. If you have not done so, you may wish to pursue other remedies that may be available to you.*



## PROVIDER REPORT FORM ATTACHMENT A

### **PROVIDER INFORMATION**

Legal Name of Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Name/Telephone Number: \_\_\_\_\_

Street Address of Provider: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### **Claim Information:**

Name of enrollee \_\_\_\_\_

Enrollee ID number \_\_\_\_\_

Date of service \_\_\_\_\_

Claim number \_\_\_\_\_

Claim amount \_\_\_\_\_

Was service preauthorized \_\_\_\_\_ Yes \_\_\_\_\_ No

### **Claim Information:**

Name of enrollee \_\_\_\_\_

Enrollee ID number \_\_\_\_\_

Date of service \_\_\_\_\_

Claim number \_\_\_\_\_

Claim amount \_\_\_\_\_

Was service preauthorized \_\_\_\_\_ Yes \_\_\_\_\_ No

### **Claim Information:**

Name of enrollee \_\_\_\_\_

Enrollee ID number \_\_\_\_\_

Date of service \_\_\_\_\_

Claim number \_\_\_\_\_

Claim amount \_\_\_\_\_

Was service preauthorized \_\_\_\_\_ Yes \_\_\_\_\_ No

### **Claim Information:**

Name of enrollee \_\_\_\_\_

Enrollee ID number \_\_\_\_\_

Date of service \_\_\_\_\_

Claim number \_\_\_\_\_

Claim amount \_\_\_\_\_

Was service preauthorized \_\_\_\_\_ Yes \_\_\_\_\_ No

### **Claim Information:**

Name of enrollee \_\_\_\_\_

Enrollee ID number \_\_\_\_\_

Date of service \_\_\_\_\_

Claim number \_\_\_\_\_

Claim amount \_\_\_\_\_

Was service preauthorized \_\_\_\_\_ Yes \_\_\_\_\_ No